City of Santa Fe

APPLICATION FOR FAMILY OR MEDICAL LEAVE

This application form is to be completed by the employee who has worked for at least 1,250 hours during the 12 month period immediately preceding the request for Family or Medical Leave.

Employee Name: _____Employee #_____

Date of Hire: _____ Department: _____ Division: _____

Current Mailing Address: _____ City,State,Zip:_____

If the request is for multiple days off for recurring medical treatments of a child, spouse, parent, or for the employee's own medical treatment, please specify dates requested.

Leave Requested begins on: _____and is expected to end:_____.

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize the City of Santa Fe to contact my physician to verify the reason for my requested leave or for any other information concerning my requested for Family or Medical Leave.

I understand that a failure to return to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the City.

Print Employee Name/Date Employee Signature

Print Supervisor Name/Date Supervisor's Signature

Division Director's Signature Department Director's Signature

APPROVED: _____ **DISAPPROVED: _____**

Human Resources Department Director **Date**

SECTION I <u>Employee's Own Serious Health Condition:</u>

____ Employee's serious health condition

____ Birth of my child

____ Adoption of a child

____ Placement (by the state) of a child with me for foster care

I have attached certification from the health care provider who is treating my own serious health condition. The certification includes the following:

1. The date on which my condition began.
2. The probable duration of my condition.
3. The appropriate medical facts within the knowledge of the health care provider regarding my condition.
4. A statement that I am unable to perform the essential functions of my position due to my condition. I have provided my health care provider with a copy of my job description.

SECTION II <u>For Care Of My Child, Parent Or Spouse With a Serious Health Condition:</u>

_____ Serious Health Condition of _____ my child

_____ my parent

_____ my spouse

I have attached a certification from the health care provider who is treating my child, parent, or spouse. The certification includes the following information:

1. The date on which the condition began.
2. The probable duration of the condition.
3. The appropriated medical facts within the knowledge of the health care provider regarding the condition.
4. An estimate of the time needed to care for the individual involved (including any recurring medical statement).
5. A statement that the condition warrants my participation to provide care.

SECTION III <u>For Leave Requested Intermittently Or A Reduced Work Schedule</u>

In addition to the above required certification, I have attached information from the health care provider that includes the following information:

1. A statement of medical necessity for intermittent leave or reduced work schedule and the duration of the schedule.
2. A listing of the date of my planned medical treatment and the duration of the treatment(s).

I certify by my signature that I have read and understand the City of Santa Fe "Family or Medical Leave Act" policy.

Print Employee Name/Date **Employee's Signature**